# *Patient Registration Form*

## Patient Information

Sex ____male ____female

patient name (first, middle initial, last)

patient's address  city  state  zip code

telephone  social security number  driver's license

_______/_______/_______ date of birth  age  ____single ____married ____separated ____divorced ____widowed marital status

spouse's name  work telephone  emergency contact other than spouse  telephone

referring doctor  telephone  whom may we thank for this referral

employer's name  telephone

employer's address  city  state  zip code

primary insurance company

secondary insurance company

## Cause of Injury

_______/_______/_______ date of accident

____yes ____no automobile accident

____yes ____no injured on job

attorney name  telephone

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made with our office.

Insurance Authorization and Assignment:
I request that payment of authorized insurance company benefits be made on my behalf to the provider of any services furnished to me by the therapist. I authorize any holder of medical information about me to release to any insurance company and its agents. I also authorize LIFEMOTION physical therapy to sign any payments made out to me for such services. Any information needed to determine these benefits or the benefits payable to related services. I understand my signature request payment be made and releases information to insurer or agency.

Consent for Treatment:
I hereby consent to be evaluated and treated for my injury or condition LIFEMOTION physical therapy, under the guidance and supervision of the licensed physical therapist.

Patient's signature:_______________________________ Date:_______________

# MEDICAL HISTORY FORM

Name:______________________________ date: _____/_____/_____

***Past History*** ***(Have you ever had?)*** — ***check if yes***

- Rheumatic fever heart murmur ______
- High Blood Pressure ______
- Disease of Arteries ______
- Varicose Veins ______
- Lung Disease ______
- Injuries to Back ______
- Epilepsy ______
- Diabetes ______
- Gout ______
- Operations ______

***Family History*** — ***check if yes***

- Heart Attacks ______
- High Blood Pressure ______
- High Cholesterol ______
- Stroke or CVA / TIA ______
- Diabetes ______
- Congenital Heart Disease ______
- Heart Operations ______
- Early Death ______
- Other: ______

***Present Symptoms*** ***(have you had recently)***

- Chest Pain / Discomfort ______
- Shortness of Breath ______
- Heart Palpitations ______
- Cough on exertion ______
- Coughing of Blood ______
- Back Pain ______
- Arthritis/Swollen, Stiff, Painful Joints ______
- Orthopedic Problems ______
  Explain if yes:
- Do you awake at Night to Urinate? ______
  Explain if yes:

***Medications*** ***(that you are taking or prescribed to you)***

- Digitalis Preparations
- Anti-Arrythmais (Quinidine, Procaine, Amides)
- Diuretics & Electrolytes
- Tranquilizers or Sedatives
- Metabolic's – Insulin, Thyroid
- Other Medications:

Allergies include-

Please List All Food and Medical Allergies

***Risk Factors***

If you smoke please circle which applies.

Cigarettes Cigar Pipe

How much per day?

What is your weight now?

Is your occupation (Please circle one)

Sedentary Active Inactive Heavy Work

Do you engage in physical activities?

Describe.

How often?

How much time a day do you exercise? (Please circle one)

| None | 15-30min | 30-45min |
| --- | --- | --- |
| 45-60min | 60-75min | 75-90min |

**PACEMAKER (CIRCLE ONE) YES / NO**

LIFEMOTION PHYSICAL THERAPY

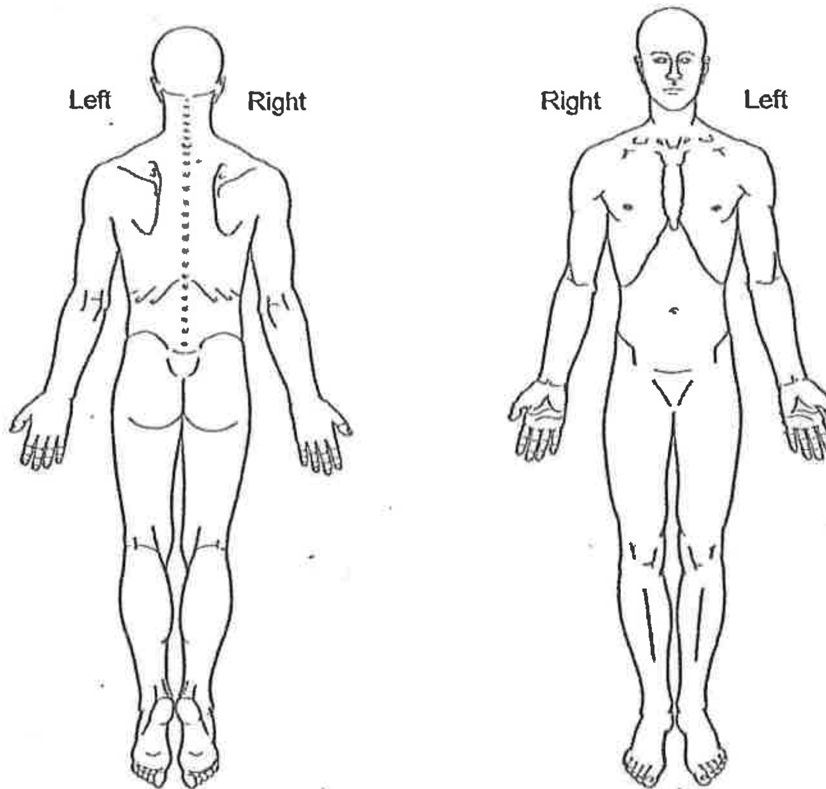
NAME: ______________________



## PAIN QUESTIONNAIRE

We would appreciate you taking some time to answer this questionnaire. It asks about your pain, and how your pain affects your life. These details will help us to better understand your needs and therefore we encourage you to fill it in as fully as possible.

**1. Where is Your Pain?**
On the diagram below please shade the areas where you experience pain.




**2. How long have you had your pain?**

______________________ (Years) ______________________ (Months)

**3. How severe is your pain?**
If zero (0) means "no pain" and ten (10) means "the worst pain you can imagine", what have been your levels of pain <u>over the last week</u>?

| | No pain | | | | | | | | | Worst pain you can imagine |
|---|---|---|---|---|---|---|---|---|---|---|
| **Lowest pain** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Highest pain** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Usual pain** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |